STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 11, 12, 13, 14, 15, and 18, 2011 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 Survey Team: Sandra Haws, RN TC Toni Krakowski, RN- April 11, 12, 13, 14, and 15, 2011 Vicki Manuwal, RN- April 11, 12, 13, 14, and 15, 2011 Bobbi Costigan, RN- April 11, 12, 14, 15, and 18, 2011 Census Bed Type: SNF/NF: 80 Residential: 48 Total: 128 Census by Payor Type: Medicare: 11 Medicaid:43 Other: 74 Total: 128 Sample: 16 Residential Sample: 7	F0000	Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2 Quality review completed on April 24, 2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of a critically ill resident's change in eating by failing to eat for an entire shift, and a temperature of 103 degrees and for failing to notify the physician regarding holding insulin for a diabetic resident. This deficient practice affected 2	F0157	Neither the signing nor the submission of this plan shall constitute an admission of any deficiency of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 16 residents reviewed for physician notification in a sample of 16. (Resident # 85, #48). Findings include: Resident # 85's closed record was reviewed on 4/14/11 at 8:00 a.m. The resident's record indicated diagnoses of, but not limited to; Alzheimer's disease, osteoporosis, glaucoma, congestive heart failure, cerebral vascular accident, transient ischemic attacks, and seizures. Nurses' notes reviewed for the resident's food consumption, dated February 17, 2011, indicated "...up in her wc (wheelchair) q (every) meal normally, consumes > (greater than) 40% of meals. Res is full assist with meals...." Nurses' notes, dated March 3, 10, 17, 24, and 31st, 2011, indicated the resident ate a pureed diet and fed by staff. The resident's record indicated at 11: 45 a.m. on 4/1/11, she experienced a ground level fall from her wheelchair. The nurses' notes indicated on 4/4/11 "Res (Resident) remains on neuro checks wnl (within normal limits) alert to self, not taking fluids or food well, no hx (history), alarms in place." The resident's record lacked documentation to indicate the physician or		law. The facility reserves the right to contest the statement of deficiencies. **F157** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. *It is the policy and practice of Hamilton Grove to notify the attending physician of any significant resident status changes in a timely manner.* For resident number 48 and 85 sufficient time has elapsed which precludes the immediate correction of this alleged deficiency, i.e. physician notification. All residents that require physician notification due to critical changes in their health status and residents receiving insulin have the potential of being affected by this finding. All nurses will be re-inserviced on the guidelines and proper assessment procedures for physician notification of change in condition by May 18, 2011. This corrected action plan will ensure that a resident undergoing significant changes in their health status will receive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the dietitian had been notified of the resident's change in food and fluid consumption. Nurses' note, dated 4/7/11 at 11:00 p.m., indicated "Weekly: Pt (patient) resting quietly in bed. Not eating this shift...no eye contact, pt breathing very shallow...." The nurses note lacked documentation to indicate the physician or dietitian had been notified of the above comments. Nurses' note, dated 4/8/11 at 6:00 a.m., indicated the resident had a decreased swallow reflex noted. The note failed to indicate the physician was notified of the change in swallowing until 1:00 p.m. the same day. Nurses' note, dated 4/9/11 at 2:00 p.m,. indicated the resident took sips of juice and ate a container of applesauce. The resident's vital signs were documented at; temperature 99.7 Biox 90 (measurement of oxygen in the blood with normal range 96 to 98%), pulse 86, blood pressure 128/70. At 11:30 p.m., on 4/9/11 the nurse's note indicated "...T (temperature) 103.0, P (pulse) 140, R (respirations) 50, B/P (blood pressure) 86/37. Mottling present to bil (bilateral) lower extremities....Resident not taking any		timely physician notification. All residents receiving insulin had physician orders clarified for parameters and notification requirements. The Director of Nursing/Designee will audit all residents receiving insulin daily for the first month then monthly thereafter. In addition, The Director of Nursing/ Designee will audit the daily communication report-daily for the next 30 days, then monthly thereafter to ensure that physician's are notified in a timely manner when a resident undergoes a critical or serious condition change. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed is: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	food/fluid po (by mouth). Resident does not open eyes, does not respond to verbal stimuli. Little or no reaction to physical stimulus...." The Resident's record failed to indicate the physician had been notified of the above comments. No order was attempted to be obtained for the 103 temperature the resident was experiencing. During an interview with the Director of Nursing on 4/14/11 at 2:15 p.m. she indicated the Resident declined rapidly after the fall. She further indicated the physician should have been notified of the high temperature the resident had experienced so an intervention could have been obtained for comfort. 2. The clinical record of Resident # 48 reviewed on 4/11/11 at 2:50 P.M., indicated diagnoses of, but not limited to, diabetes mellitus, cerebrovascular disease, hypertension, and peripheral vascular disease. A Physician Order, dated 9/15/09, indicated, "Accu Check (blood sugar test) before meals and at bedtime for DM (diabetes mellitus).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A second Physician Order, dated 12/3/10, indicated, "Novolog inj (injection) 100/ml (milliliters), inject 8 units sub q (subcutaneous) every morning for DM. Review of the 4/1/11 through 4/30/11 MAR (Medication Administration Record) indicated, Resident # 48's 5:00 A.M. Accu Check was 86. The MAR (medication administration record), Nurses's Medication Notes, dated 4/8/11 at 5:00 A.M. indicated "...glucose 86, insulin held, (nurses initials)..." Resident # 48's Care Plan, dated 3/25/11, indicated, "...Problem: (Resident # 48) has Diabetes Mellitus Type II...Interventions: 1. Administer medications as prescribed...." Review of the clinical record, lacked documentation of nursing assessment and physician notification of the insulin being held.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Interview on 4/12/11 at 4:15 P.M., LPN # 1 indicated, the record lacked documentation indicating who authorized the hold of the morning insulin dose.

The DON (Director of Nursing) on 4/12/11 at 6:00 P.M., indicated LPN # 4 stated the Resident ate only 50 % of dinner the night before so she did not feel comfortable giving the insulin because the resident has periods of unresponsiveness however she did not notify the physician of the holding of Resident # 48's insulin.

On 4/13/11 at 1:00 P.M., the DON indicated the nurse should notify the physician if a resident does not get a medication.

The DON provided a fax cover sheet on 4/15/11 at 3:15 P.M., dated 4/8/11, Time: 11-7, indicated, "...To: Doctor (Name), A.M. glucose 86, insulin held D/T (due to) slow to arouse not sure if will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	eat A.M. meal, also refused to get up per usual...", however the fax cover sheet lacked the verification stamp indicating it was faxed. A facility policy titled "Guidelines for Physician Notification for Change in Condition", non dated, indicated, "...Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner...The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate assessment...." 3.1-5(a)(2)			
F0168 SS=C	A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. Based on interviews and observation, the facility failed to ensure residents had access to information regarding contacting agencies for client advocates for 80 of 80 residents in the facility who may wish to	F0168	**F168** NO RESIDENTS WERE ADVERSLEY AFFECTED BY	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contact an advocate. Findings include: During a resident group meeting on 4/12/11 at 3:00 p.m., 11 of the 12 alert and oriented residents indicated they were not aware of any posted information available to be able to call a resident advocate if they needed to. The residents did not know where in the facility they could find this information. One resident in the meeting who requested to remain anonymous indicated she saw the form on the wall but the print was so small she couldn't read it. During a tour of the facility on 4/13/11 at 9:30 a.m. an observation was made of a framed form containing information regarding contacting the Ombudsman (a resident advocate). The framed information was observed hanging 5 feet from the ground and located in the hall near the entrance of the facility. The print on the form was very small and had to be read close up. The information would not be available to any resident in a wheelchair. 3.1-3(b)(2)		THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Grove to provide each resident of the facility appropriate advocacy agent information so they may contact these agencies any time they choose. The framed forms referenced in this alleged deficiency, were moved down so that they are now visually accessible to anyone sitting in a wheelchair. The font size of the first document is a copy of an official Indiana State Department of Health form with a complaint telephone number to call clearly legible from distances beyond five (5) feet. The font size is in excess of 28 K. The second framed form with Fourteen (14) Federal and State agencies, including the State and Area Ombudsman numbers to call or fax **IS IN 13 K LARGE CAPS, BOLD FONT TIMES, ROMAN** and **13 K small caps, bold font, Times, Roman.** Both signs are now posted approximately one foot or less above the hand rail at the main –non-licensed section of the building.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			All nursing units contained exact replicas of the same postings already at a height clearly legible by all 80 residents noted in this citation who wished to access them before the inspectors arrived on April 11, 2011 and throughout the survey process. The Administrator/ Designee will assure continued compliance by visually noting the presence and location of the Ombudsman (a resident advocate) telephone number at least weekly for four (4) weeks then quarterly thereafter to the Quality Assurance Committee. This was completed on Tuesday, **April 22, 2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observations, interviews and record review, the facility failed to ensure a care plan was updated with interventions to prevent a resident from falling out of her wheelchair (Resident # 85) and failing to update a care plan for a resident with a stage 3 pressure ulcer (Resident # 55) . This deficient practice affected 2 of 16 residents reviewed with care plans in a sample of 16. Findings include: 1. Resident # 85's closed record was reviewed on 4/14/11 at 8:00 a.m. The resident's record indicated diagnoses of, but not limited to; Alzheimer's disease,	F0279	**F279** It is the policy of Hamilton Grove to develop a comprehensive resident care plan to ensure continuity of care. These individualized care plans are based on timely resident assessments and updated at least annually, quarterly and when there is a significant change of condition. NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY.	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	osteoporosis, glaucoma, congestive heart failure, cerebral vascular accident, transient ischemic attacks, and seizures. The Resident's quarterly MDS (minimum data set) assessment dated 1/5/11 indicated the Resident's cognitive status was severely impaired. She required total assistance with 2 staff for transfers. She required total assistance for dressing, eating, and bathing. Nurses' note dated 4/1/11, 11:45 a.m. indicated "Resident leaning forward in w/c (wheelchair), alarm sounded, fell forward out of w/c before staff could reach her...." Nurses notes dated 3/3/11 (no time) indicated n/o (nursing order) for OT (occupational therapy) for w/c positioning...." Nurses note dated 3/5/11 (no time) indicated "Res (Resident) is leaning in w/c, repositioned by staff several time (sic) therapy order for OT already received." The Resident's record lacked documentation to indicate what was put in place while the resident was in her wheelchair prior to a therapy evaluation. Nurses' note dated 3/7/11, 10 (not indicated if a.m. or p.m.) Res leans to (R)		For resident number 85 sufficient time has elapsed which precludes the immediate correction of this alleged deficiency. For resident number 55, the resident' s care plan was immediately updated to include an intervention and goal to move the resident's cushion between the wheelchair and recliner or when transferred from one sitting surface to another. All residents specialty seating cushions have the potential of being affected by this finding. The corrected action plan will ensure that all residents receiving specialty wheelchair cushions will have their care plans updated to include an intervention to move their specialty seat cushion from one sitting surface to another to ensure continuity of care services. Nursing staff were re-inserviced on up-dating care plans which includes specific information regarding seat cushion transfers when a resident moves from one sitting surface to another, e.g., from wheelchair to resident's recliner or from wheelchair to dining room chair etc.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(right) in w/c at time OT has order to eval." Review of an Occupational Therapy note dated 3/7/11/ indicated "...Pt (patient) with increased risk of falls due to increased lateral leaning and forward leaning...clinical observations/assessments- pt presented in an 18 inch wide w/c with elevated leg rests, no cushion present. Pt LEs (lower extremities) were dropping off leg rests medially which, when this happened, forward flexed pt at hips... pt requires OT services to position her in w/c due to risk of falls from lateral and forward leaning which is not improving with nursing interventions...." Occupational Therapy note dated 4/5/11 after the resident fell out of her wheelchair, indicated "Final summary: Other objective gains: OT recommended w/c tipped back on rear axle, also recommended low profile air cushion modified for antithrust capabilities to prevent sacral sitting...On date of d/c (discharge), pt had leaned forward and fell out of w/c, aid reported w/c breaks (sic) were locked. Educated nursing to not leave breaks (sic) locked when pt is unattended...." Resident # 85's plan of care dated 8/20/10		Director of Nursing/Designee will audit all care plans for residents receiving specialty seating cushions for the next 30 days than 10 percent monthly thereafter to ensure care plan goals and interventions are appropriate and current. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed**: May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated "Problems: (Resident name) is at risk for falls r/t (related to) impaired safety awareness d/t her dx (diagnosis) of Alzheimer's dementia/ late affect CVA (cerebral vascular accident) and she has a hx (history) of falls in the past...." The Resident's plan of care did not address her leaning forward in her wheelchair or any interventions put in place to prevent the leaning. The recommendations from Occupational Therapy for a w/c tipped back on rear axle or the low profile air cushion modified for antithrust capabilities was not mentioned in the Resident's plan of care. The Resident's record did not indicate whether the Resident had received these items or not. During an interview with the Director of Nursing on 4/15/11 at 3:15 regarding the lack of interventions to prevent the resident from leaning and falling from her wheelchair, she indicated hourly checks were put in place. The documentation indicated the hourly checks were completed after the resident had fallen from the wheelchair. She further indicated the interventions Occupational Therapy suggested had not been put into place.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Resident # 55's clinical record was reviewed on 4/11/11 at 3:20 P.M. and indicated diagnoses of, but not limited to: osteoarthritis, osteoporosis, and hypertension. During initial tour of the East Unit on 4/11/11 at 10:25 A.M., while accompanied by LPN #1, Resident # 55 was observed sitting slouched in the recliner in her room. LPN # 1 identified her as confused, ambulatory with one person assist with an acquired open area to her coccyx. LPN # 1 indicated in an interview, at the time of the above mentioned observation, the open area to the coccyx was a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed). She further indicated Resident #55 had a low air loss mattress (a specialized mattress that intermittently distributes the fluctuation of air/pressure). When queried if Resident #55 had a specialized seat cushion to aid in the healing of the pressure ulcer, LPN #1 indicated the resident did have the specialized cushion and was seated on it. The cushion could not be observed under the resident at the time because of the way the resident was slouched in the chair. A Nurse's Note, dated 3/26/11 at 3:50	F0279	**F279** It is the policy of Hamilton Grove to develop a comprehensive resident care plan to ensure continuity of care. These individualized care plans are based on timely resident assessments and updated at least annually, quarterly and when there is a significant change of condition. NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident number 85 sufficient time has elapsed which precludes the immediate correction of this alleged deficiency. For resident number 55, the resident' s care plan was immediately updated to include an intervention and goal to move the resident's cushion between the wheelchair and recliner or when transferred from one sitting surface to another. All residents specialty seating cushions have the potential of being affected by this finding.	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., indicated, "During care CNA (Certified Nursing Assistant) called this nurse into Residents bathroom. Open area noted to below coccyx 1.5 x 0.5 x 0.3, Duo Derm (padded dressing) applied, M.D. (Medical Doctor) notified, POA (Power of Attorney) notified." During observation of wound care to resident # 55's stage III pressure ulcer on 4/12/11 at 2:05 P.M., LPN #1 asked Resident #55 to stand up from her recliner to help facilitate the wound treatment. It was observed, at that time, the pressure reducing seat cushion was not in her recliner, but rather in her wheel chair which sat vacant near her bed. CNA #20 who was assisting LPN #1 indicated she does not usually transfer Resident #55, but whoever did, forgot to put her seat cushion in her recliner before transferring her into it. Resident #55 was observed on 4/12/11 at 4:55 P.M. sitting in her wheel chair in the East Unit dining room. She did not have her seat cushion in the wheel chair. The seat cushion was observed in the recliner in her room at 4:57 P.M. At 5:00 P.M., the Director of Nursing confirmed Resident #55 was without her seat cushion while up in her wheel chair. During interview with the Director of		The corrected action plan will ensure that all residents receiving specialty wheelchair cushions will have their care plans updated to include an intervention to move their specialty seat cushion from one sitting surface to another to ensure continuity of care services. Nursing staff were re-inserviced on up-dating care plans which includes specific information regarding seat cushion transfers when a resident moves from one sitting surface to another, e.g., from wheelchair to resident's recliner or from wheelchair to dining room chair etc. Director of Nursing/Designee will audit all care plans for residents receiving specialty seating cushions for the next 30 days than 10 percent monthly thereafter to ensure care plan goals and interventions are appropriate and current. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nursing on 4/15/11 at 3:10 P.M., she indicated it was her responsibility to update the Resident's Care Plan, but she failed to do it. A Care Plan, initiated 10/05/10, indicated, "Problems: (Resident #55) is at risk for pressure ulcer development R/T (related to) impaired bed mobility...Approaches: ...Provide skin tx's (treatments) as needed/ordered...red Clock Program (turn and position every two hours). Turn (Resident #55) side to side when in bed to alleviate unwanted pressure to bony prominence's...3/29/11: Low Loss Air Mattress to bed...4/1/11: Calcium Alginate (topical wound treatment) with drsg (dressing) to lower coccyx wound...." Resident # 55's other Care Plans were reviewed, but they also lacked documentation of a pressure relieving seat cushion. A facility policy titled "Care Plans (resident Care Planning)," undated, indicated, "Purpose: to promote individualized resident care plan, with specific plans from nursing and other disciplines. To provide a tool for evaluating quality of care and goal accomplishment. To provide guidelines for nursing assignments...Procedure: ...10. Problems/needs may be prioritized if more than one is written for a		By what date the systemic changes will be completed**: May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discipline...11. The person responsible for each procedure or activity will be identified by initials in the appropriate column...." 3.1-35(a) 3.1-35(b)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure physician orders were followed for medication administration for 1 of 16 residents (Resident # 32) reviewed for medications, failed to follow physician orders related to transfer assistance for 1 of 1 residents reviewed for transfers (resident #51, and failed to follow physician orders for pressure ulcer care for 1 of 3 residents (resident #51) reviewed with pressure ulcers in a sample of 16. Findings include: 1. A. Resident # 51's clinical record was reviewed on 4/13/11 at 9:20 A.M. and indicated diagnoses of, but not limited to:	F0282	**F282** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY It is the policy of Hamilton Grove to ensure services are provided or arranged utilizing a qualified person in accordance with each resident's written plan of care. 1. For resident 32 sufficient time has elapsed to preclude immediate correction of this alleged deficiency as it relates to: (a) Metformin, (b) Misoprostol, (c) Fortical, (d) Tizainidine 2. For resident number 51 resident's transfer status was clarified to reflect	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Alzheimer's dementia, stage III pressure ulcer, and a fall with pelvic fracture times two. During initial tour of the East Unit on 4/11/11 at 10:25 A.M. while accompanied by LPN #1, she indicated Resident #51 was in contact isolation with MRSA (methicillin-resistant Staphylococcus aureus) to a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) pressure ulcer on the left heel. She further indicated Resident #51 was a two person assist for transfers and used a mechanical lift for the transfer. Resident #51's annual MDS (Minimum Data Set) Assessment, dated 2/09/11, indicated she was severely cognitively impaired and she needed extensive assist of two staff for transfers. The Care Area Assessment (CAA) Summary, dated 2/09/11, indicated, "...11. Falls: Falls triggered for (Resident #51) because her safety awareness is impaired R/T (related to) her dx (diagnosis) of Alzheimer's dementia and she has a dx. of osteoporosis, placing her at risk for injury R/T falls. Staff transfer (Resident #51) with an extensive asst (assistance) of 2 using the E-Z Stand (mechanical lift)...."		a mechanical lift and care plan updated. 3. In addition, a sock was removed from resident's foot and a new order clarified that only toes may be covered. 1A. All residents receiving mediation have the potential of being affected by this alleged deficiency. Facility's pharmacy will audit all resident medications to ensure availability of medications. In addition, a letter was reissued to resident and families who utilize outside pharmacy services, reminding them that the Hamilton reserves the right to order a resident's medication from the facility's pharmacy when outside pharmacy services fail to deliver the resident's prescription drugs in a timely manner. This letter is provided on an admission and at least annually. Furthermore, a new expanded Emergency Drug Kit (EDK) was ordered and is expected to arrive before May 18, 2011. The New EDK will contain a supply of the four medications listed in this alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, initiated 2/24/11, indicated, "Problems: (resident #51) is at risk for serious injury R/T falls D/T (due to) poor safety awareness...Approaches: Transfer (resident #51) with the use of the E-Z Stand and assist of 2 staff, positioning her extremities for safety...." During observation on 4/13/11 at 12:02 P.M., Resident # 51's room-mate was observed sitting in the East Unit dining room. CNA # 20 was observed entering Resident #51's room and greeted her. Resident #51 was lying in her bed. CNA #20 then removed her gait belt as she slowly closed the door to the room. Several minutes lapsed when CNA #20 was observed exiting Resident #51's room with her now seated in her wheel chair. No other staff exited the room with them and upon checking further, no staff was observed in the room or bathroom. CNA #20 did not take a mechanical lift into Resident #51's room to use with the transfer. CNA #20 indicated in an interview on 4/13/11 at 12:45 P.M., she was sorry she did not get another staff person to help her with the transfer of Resident #51 from her bed to the wheel chair. "I usually do. I just didn't do it today." 1. B. During initial tour of the East Unit		deficiency. The corrected action plan will ensure that all residents' medications/biologicals are available to administer at all times as prescribed by their physician. 1B. All residents with physician orders for mechanical lift for transfers have the potential of being adversely affected by this finding. All residents with physician orders for the use of mechanical lifts for transfers were reviewed and care plans updated to reflect appropriate physician orders. All Nursing staff were re-in serviced on following physician orders relative to mechanical lifts for transfers. The corrected action plan will ensure that staff will follow physician orders for mechanical transfers. 1C. For resident 51 the socks were immediately removed by nursing staff. All Residents with special physician orders for pressure ulcer care have a potential for being affected by this alleged deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 4/11/11 at 10:25 A.M., while accompanied by LPN #1, she indicated Resident #51 was in contact isolation with MRSA (methicillin-resistant Staphylococcus aureus) to an acquired stage III pressure ulcer on the left heel. Review of a Care Plan, initiated 2/24/11, indicated, "Problem: (Resident #51) has 2 unstageable pressure ulcers, one on each heel. Her bed mobility is impaired...Approaches: ...Do not apply shoes/socks to feet per MD (Medical Doctor) orders and float heels when in bed as NSG (Nursing) measure...." A Nurse's Note, dated 12/21/10 at 10 A.M., indicated, "...bilat. (bilateral) heels are dark, low loss air mattress, medboots at all times. No shoe/socks...." Resident #51's Care Area Assessment (CAA) Summary indicated, "...(Resident #51) wears Mediboots to her feet at all times, her heels are floated when in bed and she has MD orders for no shoes/socks to her feet...." During observation of wound care on 4/13/11 at 11:05 A.M. while accompanied by Physical Therapist (PT) #21, Resident #51 was observed lying in bed. She had white, fitted, cotton socks pulled up over both feet. Her bandaged left heel was		All Physician orders were reviewed for each resident receiving pressure ulcer care to ensure orders are being followed. Director of Nursing/Designee will review residents receiving pressure ulcer care daily to ensure physician orders are being followed. This will be done for 30 (thirty) days then monthly thereafter. Nursing and Therapy staff will be re-inserviced on following special physician orders for residents receiving pressure ulcer care. The corrected action plan will ensure that all special physician orders for residents receiving pressure ulcer care are appropriately followed. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fully covered by the white sock (right heel was healed). PT #21 indicated in an interview, at the time of the above mentioned observation, she was aware of the order for no socks and indicated Resident #51's socks are usually just covering her toes because they get cold. When PT #21 completed debriding Resident #51's left heel, she bandaged the wound and then covered the entire foot with the white fitted sock. She washed her hands, gathered her supplies, and left the resident's room. 2. The clinical record for Resident # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: multiple sclerosis, diabetes mellitus, esophageal reflux, and hypertension. Physician orders, dated 2/13/10, indicated, "...Metformin Tab 500 mg (milligrams), take 2 tablets (1000 mg) by mouth twice daily for diabetes...Misoprostol Tab 200 mcg (micrograms), take 1 tablet by mouth three times daily for ulcer		By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	prevention...Tizanidine Tab 4 mg, take 2 tablets (8 mg) by mouth three times daily for muscle relaxant...Fortical spr (spray) 200/ACT, instill 1 spray in alternating nostrils daily..." A physician order, dated 2/19/10, indicated, "...Tizanidine Tab 4 mg, take 3 tablets (12 mg) by mouth at bedtime..." Review of the 2/1/11 through 2/28/11 MAR (Medication Administration Record), indicated the resident did not receive the scheduled medications: Metformin -- 2/2/11, 5 P.M.; 2/3/11, 8 A.M. & 5 P.M.; 2/4/11, 8 A.M.; 2/5/11, 8 A.M., 5 P.M.; 2/6/11, 8 A.M., 5 P.M.; 2/7/11, 8 A.M., 5 P. M Misoprostol -- 2/2/11, 5 P.M.; 2/3/11, 8 A.M., 1 P.M., 5 P.M., 2/4/11, 8 A.M.; 2/5/11, 8 A.M., 1 P.M., 5 P.M.; 2/6/11, 8 A.M., 1 P.M., 5 P.M.; 2/7/11, 8 A.M., 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., 5 P.M. Tizanidine -- 2/2/11 5 P.M., 9 P.M.; 2/3/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 2/4/11, 8 A.M., 1 P.M.; 2/5/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 2/6/11, 8 A.M., 1 P.M., 9 P.M.; 2/7/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 2/10/11 9 P.M. The February 2011, MAR, Nurse's Medication Notes, indicated, "...2/2/11 No supply, Metformin, Misoprostol; 2/5/11 No supply, Metformin, Misoprostol, Tizanidine (Nurse initials); 2/5/11 No supply, Metformin, Misoprostol, Tizanidine (Nurse initials); 2/6/11 No supply, Misoprostol, Tizanidine (Nurse initials); 2/7/11 Metformin, no supply, (Nurse initials) 9 A.M.; 2/7/11 Misoprostol, no supply, (Nurse initials) 9 A.M.; 2/7/11 Misoprostol, no supply, (Nurse initials) 1 P.M. The February 2011, MAR, indicated the Resident did not receive the scheduled Metformin a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	total of 10 occasions with four documentation's specifically recorded as not given due to lack of supply; Misoprostol a total of 14 occasions with six documentation's specifically recorded as not given due to lack of supply; Tizanidine a total of 21 occasions with five documentation's specifically recorded as not given due to lack of supply. Review of the February 2011, Nurse's Notes, lacked documentation notifying the DON (Director of Nursing), MD (Medical Doctor) or family as the resident uses a mail order pharmacy of no available supply of Metformin, Misoprostol, and Tizanidine. Resident # 32's A.M. Accu Check (blood sugar) on 2/3 - 161; 2/4 - 140; 2/5 - 90; 2/6 - 113; 2/7 - 120; 2/8 - 126. Review of the 3/1/11 through 3/31/11 MAR (Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration Record), indicated the resident did not receive the scheduled medications: Fortical -- 3/18/11, 3/26/11 Tizanidine -- 3/12/11, 1 P.M., 5 P.M., 9 P.M.; 3/13/11, 8 A.M., 1 P.M., 5 P.M.; 3/14/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 3/15/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 3/16/11, 5 P.M., 9 P.M.; 3/17/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 3/18/11, 8 A.M., 1 P.M., 5 P.M., 9 P.M.; 3/19/11, 5 P.M., 9 P.M.; 3/20/11, 5 P.M., 9 P.M.; 3/21/11, 8 A.M., 5 P.M., 9 P.M. The March 2011, MAR, Nurse's Medication Notes, indicated, "...3/12/11 1 P.M. Zanaflex (Tizanidine) not given. Awaiting delivery from pharmacy...(Nurse initials); 3/12/11 5 P.M....Zanaflex not given. Awaiting delivery from pharmacy...(Nurse initials), 3/12/11 9 P.M....Zanaflex not given. Awaiting delivery from pharmacy... (Nurse initials), 3/13/11 Awaiting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Zanaflex delivery (Nurse signature), 3/15/11 5 P.M. Zanaflex is not here yet-awaiting delivery (Nurse signature), 3/15/11 9 P.M. Zanaflex is not here yet-awaiting delivery (Nurse signature), 3/17/11 5 P.M. Zanaflex on order (Nurse initials), 3/17/11 9 P.M. Zanaflex on order (Nurse initials), 3/18/11 8 A.M. Zanaflex on order (Nurse initials), 3/20/11 5 P.M. Zanaflex on order (Nurse initials), 3/20/11 9 P.M. Zanaflex on order (Nurse initials), 3/21/11 Zanaflex on order, not given (Nurse initials), 3/21/11 Zanaflex on order, not given (Nurse initials)...3/18/11, 8 A.M.-out of Fortical, on order (Nurse initials) 3-18; 3/26, Fortical N/A (not available) en route from pharmacy (Nurse initials)..." The March 2011, MAR, indicated the Resident did not receive the scheduled Fortical a total of two occasions with two documentation's specifically recorded as not given due to lack of supply; Tizanidine a total of 33 occasions with 13			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation's specifically recorded as not given due to lack of supply. Review of the March 2011, Nurse's Notes, lacked documentation notifying the DON, MD, or family of no available supply of Fortical and Tizanidine. Review of the 4/1/11 through 4/13/11 MAR (Medication Administration Record), indicated the resident did not receive the scheduled medication: Metformin -- 4/3/11, 5 P.M.; 4/6/11, 5 P.M.; 4/7/11, 5 P.M.; 4/8/11, 8 A.M., 5 P.M.; 4/10/11, 5 P.M.; 4/11/11, 8 A.M.; 4/12/11, 8 A.M., 5 P.M.; The April 2011, MAR, Nurse's Medication Notes, indicated, "...4/6/11 Metformin, No supply; 4/7/11 Metformin, No supply (Nurse signature); 4/12/11 Metformin, No supply (Nurse signature); 4/13/11 late entry -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Metformin N/A 4/8/11 - ordered from CVS N/C (Nurse initials); 4/13/11 late entry - Metformin N/A 4/9/11 (Nurse initials); 4/13/11 late entry for 4/11/11 - Metformin N/A (Nurse initials); 4/13/11 late entry for 4/12/11 - Metformin N/A (Nurse initials)..." The April 2011, MAR, indicated the Resident did not receive the scheduled Metformin a total of nine occasions with seven documentation's specifically recorded as not given due to lack of supply. Review of the April 1 through April 13, Nurse's Notes, lacked documentation notifying the DON or family of no available supply of Metformin. A fax cover sheet, undated, to Dr. (name), faxed on 4/13/11 at 12:15 P.M., indicated, "...(Resident # 32) has been without Metformin since 4/8/11...." Resident # 32's A.M. Accu Check on 4/4 - 72; 4/7 - 122; 4/8 - 122; 4/9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 80; 4/11 - 200; 4/12 - 157; 4/13 - 75. A Comprehensive Metabolic Panel (lab test), drawn 2/1/11, indicated, "...Glucose (sugar level) 289 H (high), normal level 64-105 mg/dL..." Resident # 32's Care Plan's, dated 12/2010, indicated, "...Diabetes Mellitus Type II...Administer medications as prescribed... Interview with LPN # 1 on 4/13/11 at 10:40 A.M., she indicated that a medication can be ordered from the local pharmacy in New Carlisle or South Bend for back up medications when a resident runs out or they can pull the medication from the emergency drug kit (EDK) if it is available. On 4/13/11 at 1:00 P.M., the DON (Director of Nursing) indicated the nurse should notify the physician if a resident does not get a medication. She further indicated if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident uses a mail order pharmacy and the medication is not available, the facility should get it from the local pharmacy. A memo from the DON addressed to Nurses regarding outside pharmacy medication, dated 4/12/2011, 9:35 A.M., indicated, "...Families and/or Residents are to provide us with the outside pharmacy medications, but if they fail to do so, it is still our responsibility to make sure the medications are administered as ordered by their physician...." The Lippincott Manual of Nursing Practice Handbook, Third Edition, indicated, "...Diabetes Mellitus...Pharmacologic Interventions...Oral hypoglycemic agents...Metformin 1,000-2,550 mg in two to three divided doses with meals...Multiple Sclerosis...Pharmacologic Interventions...Centrally acting muscle relaxants...to control spasticity...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy titled "Administration of Medications, Oral", undated, indicated, "...If a resident refuses or is unable to take a medication...write note as to reason in the nurses' notes and/or on the reverse side of the medication record...notify physician...inability to take medications...Document in the medical record..." 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview, record review, and observations, the facility failed to provide the necessary incontinence care for 1 of 1 residents dependent for incontinence care in a sample of 16. (Resident #32) Findings include: The clinical record of Resident #32 was reviewed on 4/13/2011 at 11:00 a.m.. Resident #32's diagnoses include, but were not limited to, neurogenic bladder with suprapubic catheter, multiple sclerosis, muscle weakness, and history of urinary tract infections. During a tour on 4/11/2011 at 10:25 a.m., of the Center Unit accompanied by LPN #2, she indicated Resident #32 was alert and oriented times three. During Medication pass on 4/12/2011 at 5:10 p.m. and 4/12/2011 at 5:40 p.m., a strong urine odor was noted during both observations. Resident #32's bed was observed to have a wet beach ball sized area with a palm sized amount of brown matter in the center.	F0312	**F312** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. It is the policy and practice of this facility to assist all dependent residents with their ADL care in order to maintain good nutrition, grooming, personal and oral hygiene. For resident # 32 sufficient time has expired to preclude the immediate correction of this finding. All residents dependent for incontinence care have the potential of being affected by this finding. All nursing staff will be re-inserviced on continence care as it affects resident's hygiene which includes but is not limited to: timely change of linen, soiled continent pads, resident garments to ensure maintenance of each resident's personal hygiene. The corrected action plan will ensure that all dependant residents requiring	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with CNA #3 on 4/12/2011 at 6:20 p.m.. During the interview, CNA #3 stated he assisted Resident #32 out of bed around 4:50 p.m., to bring her to dinner. CNA #3 stated the resident was soiled due to incontinence. CNA #3 stated he changed the bed, put new linens and pads on the bed, completed perineal care and placed a new incontinence brief on the resident. An Interview was completed with alert and oriented Resident #32 on 4/12/2011 at 6:37 p.m. The resident stated she is still wet from her suprapubic catheter leaking. The Resident stated she did not have an incontinence pad on currently. An Interview was completed with the DON on 4/12/2011 at 6:40 p.m. The DON indicated the wet area was due to perspiration. During an observation on 4/12/2011 at 6:42 p.m., CNA #3 came to the Resident's room and removed soiled sheets from Resident #32's bed. Review of Resident #32's Quarterly MDS (Minimum Data Set) Assessment, dated 2/9/2011, indicated Resident #32 needed extensive assist for transfer and she was frequently incontinent of bowel.		continent care receive the necessary services in a timely manner to maintain good grooming and personal hygiene. The Director of Nursing/Designee will observe at least four dependent residents requiring continent care at least five days a week at various times and different shifts for 30 (thirty days) then five (5) residents monthly for two months, then five (5) quarterly thereafter. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=G	3.1-38(a)(2) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to prevent the development of Stage III pressure ulcers for 2 of 3 residents in a sample of 16. Residents: #55, #51 Findings include: 1. Resident # 55's clinical record was reviewed on 4/11/11 at 3:20 P.M., and indicated diagnoses of, but not limited to: osteoarthritis, osteoporosis, and hypertension. During initial tour of the East Unit on 4/11/11 at 10:25 A.M., while accompanied by LPN #1, Resident # 55 was observed sitting slouched in the recliner in her room. LPN # 1 identified	F0314	**F314** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Grove to ensure residents who are admitted to our facility without pressure areas do not develop them unless the individual's clinical condition demonstrates that they are unavoidable. For resident number 55 and 51 sufficient time has expired to preclude the immediate correction of this finding. Although the specialty cushion was immediately transferred and placed underneath the resident. 1. For residents 55 and 51 the	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her as confused, ambulatory with one person assist with an acquired open area to her coccyx. LPN # 1 indicated in an interview, at the time of the above mentioned observation, the open area to the coccyx was a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed). She further indicated Resident #55 had a low air loss mattress (a specialized mattress that intermittent distributes the fluctuation of air/pressure). When queried if Resident #55 had a specialized seat cushion to aid in the healing of the pressure ulcer, LPN #1 indicated the resident did have the specialized cushion and was seated on it. The cushion could not be observed under the resident at the time because of the way the resident was slouched in the chair. A Nurse's Note, dated 3/26/11 at 3:50 P.M., indicated, "During care CNA (Certified Nursing Assistant) called this nurse into Residents bathroom. Open area noted to below coccyx 1.5 x 0.5 x 0.3, Duo Derm (padded dressing) applied, M.D. (Medical Doctor) notified, POA (Power of Attorney) notified." A "Skin Care Management Form," dated 3/26/11, indicated: "Site: below coccyx...This condition developed after		following wound treatments have been initiated. 2. Low loss alternating flow air mattress 3. Wound treatments per physician orders 4. Wheelchair cushions 5. Reviewed by a certified wound care nurse every four (4) weeks 6. Registered Dietician reviews weekly and recommendations are provided/communicated to staff as needed. 7. Weekly weights 8. Occupational Therapist screen 9. Skin checks during showers – to be performed by both nurses and CNAs 10. Updated Braden scales All residents receiving an accurate Braden scale that identifies them as high risk for skin break down have the potential to be affected by this finding as well as residents requiring extensive assistance or greater (dependent residents) and 2 person assist as identified by the MDS. For wound prevention all new admissions will be assessed using the accurate Braden scale as a baseline to establish level of risk. For residents at high risk they will receive the following: 1. A therapeutic type mattress that assists in reducing pressure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission: Yes...Date: 3/26/11, Type: Pressure, Status III (stage III), Length/width (cm) (centimeters): 1.5 x 0.5 cm, Depth (cm): 0.3 cm...Color: pink, Drainage (amount/type): scant blood...Date: 4/2/11, Type: pressure, Status: Stage III, Length/Width (cm) 1.3 x 0.5, Depth: 0.5 cm...Color: pink, Drainage (amount/type): clear to yellow...Date: 4/9/11, Type: (blank), Status: III, Length/Width (cm) 1.3 x 0.5, Depth (cm): 0.4...Color: pink, Drainage (amount/type): yellow...." Resident #55's "Skin Care Management Form," indicated she did not have any previous pressure ulcers. During observation of wound care to resident # 55's Stage III pressure ulcer on 4/12/11 at 2:05 P.M., LPN #1 asked Resident #55 to stand up from her recliner to help facilitate the wound treatment. Resident #55's wound appeared to be about the size of a dime with a deep crater with a creamy yellow center (slough) and located at the coccyx (base of the vertebral column and sacrum). The old dressing removed by LPN #1 had a slight, yellow, moist, stain on it. It was observed, at that time, the pressure reducing seat cushion was not in her recliner, but rather in her wheel chair which sat vacant near her bed. CNA #20 who was assisting LPN #1 indicated she does not usually transfer Resident #55, but whoever did,		while resident is lying in bed 2. A basic pressure redistribution cushion 3. Enrolled in the red clock (turning and repositioning) program 4. Registered Dietician review For all residents requiring extensive assistance or greater (dependent residents) 2 person assist will receive the following interventions: 1. A therapeutic type mattress that assists in reducing pressure while resident is lying in bed 2. A basic pressure redistribution cushion 3. Enrolled in the red clock (turning and repositioning) program 4. Registered Dietician review 5. Heal protection as deemed necessary The corrected action plan will ensure that residents who enter our facility will not develop pressure areas. Skin sweeps were completed on May 3, 2011. Any areas identified are receiving appropriate treatment. All Nursing staff will be re-inserviced regarding wound prevention protocol. Director of Nursing/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	forgot to put her seat cushion in her recliner before transferring her into it. Resident #55 was observed on 4/12/11 at 4:55 P.M., sitting in her wheel chair in the East Unit dining room. She did not have her seat cushion in the wheel chair. The seat cushion was observed in the recliner in her room at 4:57 P.M. At 5:00 P.M., the Director of Nursing confirmed Resident #55 was without her seat cushion while up in her wheel chair. Resident # 55's most recent quarterly MDS (Minimum Data Set) Assessment, dated 3/02/11, indicated she was frequently incontinent of urine and needed extensive assist of 1 for toileting. A Care Plan, initiated 10/05/10, indicated, "Problems: (Resident #55) is at risk for pressure ulcer development R/T (related to) impaired bed mobility...Approaches: ...Provide skin tx's (treatments) as needed/ordered...red Clock Program (turn and position every two hours). Turn (Resident #55) side to side when in bed to alleviate unwanted pressure to bony prominence's...3/29/11: Low Loss Air Mattress to bed...4/1/11: Calcium Alginate (topical wound treatment) with drsg (dressing) to lower coccyx wound...." Resident # 55's other Care Plans were reviewed, but they also lacked		review all residents to determine level of risk for skin breakdown. Those identified at high risk were provided a therapeutic type mattress, a basic pressure redistribution cushion and enrolled in the red clock program. The Director of Nursing/Designee will review at least 12 residents weekly for thirty (30) days then 12 monthly for the next ninety days thereafter to ensure wound prevention interventions continue in place and to identify others whose risk status may have changed since the last assessment. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. New therapeutic mattresses (20 in all) that assist in reducing pressure and basic redistribution seat cushions have been ordered to ensure all residents receive this wound prevention intervention. Their arrival is anticipated before May 18, 2011 but due to transportation, warehouse on hand	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of a pressure relieving seat cushion. An Interdisciplinary Care Plan Progress Note, dated 3/16/11, indicated, "...Not much motivation. Sits in common area and watches people. No mood behavior problems. Cooperative with care...." A "Braden Scale for Predicting Pressure Sore Risk," dated 2/28/11, indicated a score of 15 (low risk) for Resident #55. Review of the Resident Assessment Protocol Summary (RAP), dated 9/25/10, indicated, "...Pressure ulcers triggered for (resident #55) because her bed mobility is impaired, placing her at risk for pressure ulcer development and she has a hx (history) of pressure ulcers in the past...." 2. During initial tour of the East Unit on 4/11/11 at 10:25 A.M. while accompanied by LPN #1, she indicated Resident #51 was in contact isolation with MRSA (methicillin-resistant Staphylococcus aureus) to an acquired stage III pressure ulcer on the left heel. Outside the room was a free-standing 3 drawer cabinet which contained gloves and gowns to be worn when providing care to Resident #51. Laboratory reports, dated 3/02/11 and		availability delivery could be delayed beyond May 18, 2011. By what date the systemic changes will be completed: **May 18, 2011** **Please refer to Exhibit 1 attached. FYI** Hamilton Grove administration recognizes the increased number of residents receiving a diagnosis of PVD. In an effort to assure timely follow up, the medical director will communicate to the podiatrist that when a resident presents signs or symptoms suggesting a new diagnosis, this information should be conveyed immediately to either the primary care physician or medical director. They will then determine whether follow up testing is required to confirm and/ or treat the suspected diagnosis. The DON/Designee will review the podiatrist's clinical notes monthly and communicate any new signs or symptoms to the primary care physician/medical director for follow up treatment and/or recommendations. The Administrator/Designee will submit these findings to the Quality Assurance Committee for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

3/21/11, indicated the wound to the left heel of Resident #51 was positive for MRSA.

A "Change of Condition Form," dated 3/09/11, indicated, "...Problem: MRSA to L (left) heel wound. Interventions: ...2. Contact Isolation...."

During observation of wound care on 4/13/11 at 11:05 A.M. while accompanied by Physical Therapist (PT) #21, Resident #51 was observed lying in bed. PT #21 addressed the resident and set her supplies up to debride the stage III pressure ulcer on Resident #51's left heel. She removed the old dressing which contained a quarter-sized serosanguineous (thin and light red tinged drainage) spot. The wound was a beefy red dime-sized crater surrounded by creamy white tissue. No eschar (a dry crust that results from trauma) was present.

A Nurse's Note, dated 12/11/10 at 10:30 P.M., was the first note indicating the development of the pressure ulcers to Resident #51's heels, "Res (resident) was found to have blisters on both heals (sic) this afternoon. Both are intact, both are black in color."

A "Doctor Progress Notes," dated 12/17/10, indicated, "...Developed dark

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	blisters to bilat (bilateral) heels. ? friction. No obvious injury...Ext (extremities): L (left) heel with soft large hemorrhagic blister. No SOI (sign of infection). R (right) heel with flat, dried blister? unopened. No SOI. Resident #51's annual MDS (Minimum Data Set) Assessment, dated 2/09/11, indicated, she had one "unstageable pressure ulcer with suspected deep tissue injury in evolution...Pressure ulcer length: 2.5 cm (centimeters); Pressure ulcer width: 1.5 cm.; Pressure ulcer depth: 0 cm...." A Care Plan, initiated 2/24/11, indicated, "Problem: (resident #51) has 2 unstageable pressure ulcers, one on each heel...Approaches: ...(3/17/11) cleanse L heel with NS (normal saline) or wound cleaner. Apply Santyl (chemical debrider) to wound bed then apply Calcium Alginate (thin pad with wound healing medication), cover with foam drsg (dressing) bid (twice daily)." The "Change of Condition Forms," indicated the following: "12/11/10: Issue/Concern: Both heals (sic) have intact blisters, both are black in color...Problem: blisters to both heals (sic), blisters are intact with no drainage,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	blisters are black in color...2/2/11: Problem: Abt (antibiotic)/ (left) heel...2/11/11: Problem: Open area bilat (bilateral) heel (s)...3/9/11: Problem: MRSA to L heel wound...." A "Doctor Progress Note," dated 3/2/11, indicated, "...increased d/c (discharge) and odor to L (left) heel wound...L heel with enlarging wound with exudative base and redness surrounding...heel wound with infection...." A "Doctor Progress Notes," dated 3/16/11, indicated, "...R (right) heel healed. L heel + (positive) MRSA...." A Nurse's Note, dated 2/15/11 (no time) indicated, "...Tx (treatment) cont (continues) to bilat (bilateral) heels...Res (resident) has dx (diagnosis) PVD (peripheral vascular disease) bilateral feet...." Review of Resident #51's diagnoses in her clinical record (Doctor Progress Notes, Hospital Reports, History and Physical) did not indicate a diagnosis of PVD, however, a Podiatry Progress Note, dated 11/11/10, indicated PVD was circled as a diagnosis for Resident #51. During an interview with Dr. (Name) on 4/13/11 at 12:40 P.M., she indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #51 had a good pedal pulse. She further indicated, when queried about circulation in Resident # 51's lower legs, the right heel healed up without difficulty and the left heel should do the same as soon as the MRSA treatment is completed. She also indicated she did not give her the diagnosis of PVD, but saw it on the podiatry note. "The family has requested comfort measures only so I have not pursued an arterial blood flow study. That test would be the way to diagnose if she had PVD." Review of 40 clinical records in the facility indicated all of those residents had a diagnosis of PVD on their Podiatry Progress Note, but the PVD diagnosis did not appear on their History and Physical or admission diagnoses. 3.1-40(a)(1) 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure effective interventions were in place to prevent a	F0323	**F323** NO RESIDENTS WERE ADVERSLEY AFFECTED BY	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident with a known history of leaning while in the wheelchair from falling for 1 of 4 residents reviewed with a history of falls in the sample of 16. (Resident # 85) Findings include: Resident # 85's closed record was reviewed on 4/14/11 at 8:00 a.m. The resident's record indicated diagnoses of, but not limited to; Alzheimer's disease, osteoporosis, glaucoma, congestive heart failure, cerebral vascular accident, transient ischemic attacks, and seizures. Nurses' note, dated 4/1/11, 11:45 a.m., indicated "Resident leaning forward in w/c (wheelchair), alarm sounded, fell forward out of w/c before staff could reach her...." Nurses notes, dated 3/3/11 (no time), indicated n/o (nursing order) for OT (occupational therapy) for w/c positioning...." Nurses note, dated 3/5/11, (no time) indicated "Res (Resident) is leaning in w/c, repositioned by staff several time (sic) therapy order for OT already received." Nurses' note, dated 3/7/11, 10 (not indicated if a.m. or p.m.) Res leans to (R)		THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Grove to ensure that the environment is free from hazards. For resident number 85 sufficient time has elapsed which preclude the correction of this alleged deficiency. All residents receiving therapy seating recommendations for supportive posturing which may prevent falls have a potential of being affected by this finding. The Director of Nursing/Designee will review all therapy recommendations daily at least 5 days a week for sixty days then monthly thereafter to ensure therapy seating recommendations are followed through. Nursing staff will be re-inserviced regarding follow-up with therapy recommendations. The corrected action plan will ensure that residents will receive proper services as recommended by therapy staff. The Administrator/Designee will review these findings weekly and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(right) in w/c at time OT has order to eval." Review of an Occupational Therapy note, dated 3/7/11, indicated "...Pt (patient) with increased risk of falls due to increased lateral leaning and forward leaning...clinical observations/assessments- pt presented in an 18 inch wide w/c with elevated leg rests, no cushion present. Pt LEs (lower extremities) were dropping off leg rests medially which, when this happened, forward flexed pt at hips... pt requires OT services to position her in w/c due to risk of falls from lateral and forward leaning which is not improving with nursing interventions...." Occupational Therapy note, dated 4/5/11 after the resident fell out of her wheelchair, indicated "Final summary: Other objective gains: OT recommended w/c tipped back on rear axle, also recommended low profile air cushion modified for antithrust capabilities to prevent sacral sitting...On date of d/c (discharge), pt had leaned forward and fell out of w/c, aid reported w/c breaks (sic) were locked. Educated nursing to not leave breaks (sic) locked when pt is unattended...." Resident # 85's plan of care, dated		submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/20/10, indicated "Problems: (Resident name) is at risk for falls r/t (related to) impaired safety awareness d/t her dx (diagnosis) of Alzheimer's dementia/ late affect CVA (cerebral vascular accident) and she has a hx (history) of falls in the past...." The Resident's plan of care did not address her leaning forward in her wheelchair or any interventions put in place to prevent the leaning. The recommendations from Occupational Therapy for a w/c tipped back on rear axle or the low profile air cushion modified for antithrust capabilities was not mentioned in the Resident's plan of care. The Resident's record did not indicate whether the Resident had received these items or not. A form titled Fall Risk Assessment, dated 10/19/10 and 1/13/11, both indicated a score of 9. A total score above 10 represented high risk for falls. The form indicated if the Resident had 3 or more predisposing diseases present she would score a 4 for this section. The Resident's form indicated a score of 2. The Resident had 3 of the following diagnoses CVA, Osteoporosis and Seizures. The correct scoring of 4 for these dates would have put the score at 14 instead of 9, putting her at high risk.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the Director of Nursing on 4/15/11 at 3:15 p.m., regarding the lack of interventions to prevent the resident from leaning and falling from her wheelchair, she indicated hourly checks were put in place. The documentation indicated the hourly checks were completed after the resident had fallen from the wheelchair. 3.1-45(2)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observaton , record review and interview, the facility failed to ensure a medicaton error rate of less than 5% for 2 of 19 residents observed receiving medicatons . Three errors in medicaton administraton were observed during 40 opportunites for error. This resulted in a medicaton error rate of 7.5 % (Resident # 40, #32,) Findings include: 1. During medication pass observation on 4/14/11 at 11:35	F0332	**F332** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident # 40 and 32 sufficient time has elapsed to preclude immediate correction of this alleged deficiency as it relates to: (1) eye drops, (2) coumadin, (3) Metformin. However, new medication was ordered immediately and received the same day.	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.M., LPN # 1 instilled two drops of Alphagan P into each eye of Resident # 40. The clinical record for Resident # 40, reviewed on 4/12/11 at 1:15 P.M., indicated diagnoses of, but not limited to: glaucoma, diabetes mellitus, hypertension, and renal failure. A physician order, dated 11/22/10, indicated "...Alphagan P (eye drop for Glaucoma) sol (solution) 0.15%, Instill 1 drop in both eyes twice daily..." The care plan for Resident # 32, dated 12/2010, indicated, "...administer medications as prescribed...." Interview with LPN # 1 on 4/14/11 at 11:40 A.M., she indicated she gave the resident two drops in each eye but should have been one drop. Review of the Alphagan P package insert, printed on 4/18/11 at 1:07		All residents receiving medication have potential of being affected by this alleged deficiency. Hamilton's pharmacy will provide a Licensed Nurse to perform at least 2 supervised medication passes which includes various routes of medication administration weekly on varying shifts for four weeks, then one monthly thereafter. The corrected action plan will ensure that residents will receive the correct medication dosage per physician orders. The facility's contracted pharmacy will audit all medication carts by May 18, 2011 to ensure both availability of medications and medication dosages are dispensed accurately. All nursing staff will be re-inserviced regarding the five R's of medication administration The right medication, the right dosage, the right resident, at the right time and the right route. Director of Nursing/Designee will observe at least 12 medication passes during the next 30 (thirty) days which includes various routes of medication administration on varying shifts then three med passes quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., indicated, "...No information is available on overdosage in humans...." A facility policy titled "Administration of Medications, Oral", undated, indicated, "Always adhere to the five rights of medication administration...right dose...Check medication label with order sheet..." 2. a. During medication pass on 4/12/11 at 5:40 P.M., LPN # 2 dispensed Warfarin (Coumadin) 4 mg to Resident # 32. The clinical record for Resident # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: deep vein thrombosis, multiple sclerosis, diabetes mellitus, and hypertension. A physician order, dated 3/16/11, indicated "Coumadin 4.5 mg (milligrams) 1 po (orally) daily. Recheck PT/INR (lab test to		thereafter. Those staff members found to be out of compliance with facility policy will be subject to one on one instruction/reeducation. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	determine clotting rate) on 3/23/11..." A second physician order, dated 3/24/11, indicated "...Coumadin 4.5 mg 1 po Monday thru Friday..." Resident # 32's care plan, dated 12/2010, indicated, "...3/24/11 Coumadin 4.5 mg daily M (Monday) - F (Friday)..." Interview with LPN # 2 on 4/13/11 at 3:30 P.M., she indicated the resident has been receiving 4 mg of Coumadin instead of the prescribed 4.5 mg. LPN # 2 did not indicate how many times this had occurred. 2.b. During Medication Pass on 4/12/11 at 5:40 P.M., LPN # 2 indicated she could not locate Resident # 32's Metformin; therefore the resident did not receive the medication. The clinical record for Resident # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: deep vein			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	thrombosis, multiple sclerosis, diabetes mellitus, and hypertension. Physician orders, dated 2/13/10, indicated, "...Metformin Tab 500 mg (milligrams), take 2 tablets (1000 mg) by mouth twice daily for diabetes... Interview with LPN # 1 on 4/13/11 at 10:40 A.M., she indicated medications can be ordered from the local pharmacy in New Carlisle or South Bend for back up medications when a resident runs out or they can pull the medication from the emergency drug kit (EDK) box if it is available. 3.1-25(b)(9) 3.1-48(c)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors related to the incorrect dose of Coumadin being administered (Resident # 32) for 1 of 19 residents observed during medication pass in a sample of 6. Findings include: The clinical record for Resident # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: deep vein thrombosis, multiple sclerosis, diabetes mellitus, and hypertension. A physician order, dated 3/16/11, indicated "Coumadin 4.5 mg (milligrams) 1 po (orally) daily. Recheck PT/INR (lab test to determine clotting rate) on 3/23/11..." A second physician	F0333	**F333** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident number 32 sufficient time has elapsed to preclude immediate correction for the dates identified on this alleged deficiency. All residents receiving medication have potential of being affected by this alleged deficiency. For the date the surveyor received the clinical record for resident number 32, the nurse immediately ordered coumadin from the pharmacy and received it within the allotted time of med pass (1 hour before or 1 hour after). There were no more interruptions in medication administration for this resident. All nursing staff will be re-inserviced regarding the five R's of medication administration The right medication,	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order, dated 3/24/11, indicated "...Coumadin 4.5 mg 1 po Monday thru Friday..." This indicated the Resident had been receiving the wrong dose from at least 3/16/11 through 3/24/11 when the new order was received. During medication pass on 4/12/11 at 5:40 P.M., LPN # 2 dispensed Warfarin (Coumadin) 4 mg to Resident # 32. Review of the PT/INR (lab test), indicated the following: 3/23/11 PT (Prothrombin time) 17.6 H (high), normal level 9.0-12.0 sec; 3/28/11 PT 25.8; 4/5/11 PT 28.5; 4/13/11 PT 22.0 Resident # 32's care plan, dated 12/2010, indicated, "...3/24/11 Coumadin 4.5 mg daily M (Monday) - F (Friday)..." Interview with LPN # 2 on 4/13/11 at 3:30 P.M., she indicated the resident has been receiving 4 mg of		the right dosage, the right resident, at the right time and the right route. The facility's contracted pharmacy will audit all medication carts by May 18, 2011 to ensure both availability of medications and medication dosages are dispensed accurately. The corrected action plan will ensure that residents will receive the right medication in the right dosage. Director of Nursing/Designee will review all residents receiving coumadin to ensure the physician orders accurately correspond to the available medication. This will be done weekly for 30 days then monthly thereafter. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Coumadin instead of the prescribed 4.5 mg. LPN # 2 did not indicate how many times this had occurred. The 2010 Nursing Spectrum Drug Handbook, indicated, "...Be aware that Warfarin is a high-alert drug...Certain drugs expose patients to an increased risk of significant harm when used in error..." The Lippincott Manual of Nursing Practice Handbook, Third Edition, indicated, "...Deep Vein Thrombosis...monitor PT...check results before giving next anticoagulant dose. Dosage may be adjusted to achieve desired elevation of these levels..." A facility policy titled "Administration of Medications, Oral", undated, indicated, "Always adhere to the five rights of medication administration...right dose...Check medication label with order sheet..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-25(b)(9) 3.1-48(c)(2)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure the ordered medications were available (Resident # 32) for 1 of 19 residents observed during medication pass.	F0425	**F425** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. It is the policy of Hamilton Grove to provide routine, emergency medications and biological to all	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The clinical record for Resident # 32, reviewed on 4/13/11 at 11:00 A.M., indicated diagnoses of, but not limited to: deep vein thrombosis, multiple sclerosis, diabetes mellitus, and hypertension. Physician orders, dated 2/13/10, indicated, "...Metformin Tab 500 mg (milligrams), take 2 tablets (1000 mg) by mouth twice daily for diabetes...Misoprostol Tab 200 mcg (micrograms), take 1 tablet by mouth three times daily for ulcer prevention...Tizanidine Tab 4 mg, take 2 tablets (8 mg) by mouth three times daily for muscle relaxant...Fortical spr (spray) 200/ACT, instill 1 spray in alternating nostrils daily..." A physician order, dated 2/19/10, indicated, "...Tizanidine Tab 4 mg, take 3 tablets (12 mg) by mouth at bedtime..." Review of the 2/1/11 through		residents living in our facility. For resident #32 sufficient time has elapsed which preclude the immediate correction of this alleged deficiency as it pertains to the unavailability of the following medications at the time of the inspectors survey: Metformin, Misoprostol, Tizanidine, and Fortical. For Resident # 32 Metformin Tab 500 mg (milligrams) Misoprostol, Tizanidine Tab 4 Mg and Fortical (spray) 200/ACT were immediately reordered and received through the resident's pharmacy. All residents receiving medications have a potential of being adversely affected by this finding. All nursing staff will be re-inserviced regarding the use of Hamilton's contracted pharmacy services. That is, when a resident's medication supply is within 3 day of depletion the nurse unit manager will be responsible for reordering a new supply of medications from the facility pharmacy. In addition, a letter was reissued to resident and families who utilize outside pharmacy services, reminding them that the Hamilton reserves	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/28/11 MAR (Medication Administration Record), indicated the resident did not receive the scheduled medication doses: Metformin a total of 10 occasions with four documentation's specifically recorded as not given due to lack of supply; Misoprostol a total of 14 occasions with six documentation's specifically recorded as not given due to lack of supply; Tizanidine a total of 21 occasions with five documentation's specifically recorded as not given due to lack of supply. Review of the 3/1/11 through 3/31/11 MAR indicated the resident did not receive the scheduled medication doses: Fortical a total of two occasions with two documentation's specifically recorded as not given due to lack of supply; Tizanidine a total of 33 occasions with 13 documentation's specifically recorded as not given due to lack of supply.		the right to order a resident's medication from the facility's pharmacy when outside pharmacy services fail to deliver the resident's prescription drugs in a timely manner. This letter is provided on admission and at least annually. Furthermore, a new expanded Emergency Drug Kit (EDK) was ordered and is expected to arrive before May 18, 2011. The New EDK will contain a supply of the four medications listed in this alleged deficiency. In addition, pharmacy will audit all medication carts by May 18, 2011 to ensure the availability of all resident medications. The corrected action plan will ensure that all residents medications/ biologicals are available to administer at all times as prescribed by their physician. The DON/designee will audit all resident medications/biologicals for availability weekly for 60 days then monthly thereafter. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the 4/1/11 through 4/13/11 MAR indicated the resident did not receive the scheduled medication doses: Metformin a total of nine occasions with seven documentation's specifically recorded as not given due to lack of supply. During Medication Pass on 4/12/11 at 5:40 P.M., LPN # 2 indicated she could not locate Resident # 32's Metformin; therefore the resident did not receive the medication. Interview with LPN # 1 on 4/13/11 at 10:40 A.M., she indicated medications can be ordered from the local pharmacy in New Carlisle or South Bend for back up medications when a resident runs out or they can pull the medication from the emergency drug kit (EDK) box if it is available. On 4/13/11 at 1:00 P.M., the DON (Director of Nursing) indicated if the resident uses a mail order pharmacy and the medication is not		monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	available, the facility should get it from the local pharmacy. A memo from the DON addressed to Nurses regarding outside pharmacy medication, dated 4/12/2011, 9:35 A.M., indicated, "...Families and/or Residents are to provide us with the outside pharmacy medications, but if they fail to do so, it is still our responsibility to make sure the medications are administered as ordered by their physician...." 3.1-25(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to dispose of expired medications in a timely manner in 3 of 4 medication carts and 1 of 2 medication rooms. This deficient practice had the potential to affect 5 of 80 residents.	F0431	**F431** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY. For resident # 10, 27, 35, 39 and 46 all dated medications cited were immediately removed from the	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Residents: # 10 # 27, # 35, # 39 # 46, During inspection of the medication carts, the following expired medications were observed: East Hall Medication Cart on 4/14/11 at 1:45 P.M.: Resident # 46: One bottle of Xalatan 0.005% eye drops, fill date 12/17/10, no open date, discard date 1/28/11. Resident # 46: One bottle of Xalatan 0.005% eye drops, fill date 11/19/10, open date 2/2/11, discard date 12/31/10. Center Medication Cart # 1 on 4/14/11 at 2:10 P.M.: Resident # 27: one Metoprolol Tartrate (blood pressure) 50 mg (milligrams), fill date 3/16/10, discard date 3/16/11; two Furosemide (water pill) 40 mg, fill		medication cart and appropriately discarded. New medications were provided by the facility's and resident's pharmacy. All residents receiving medication have potential of being affected by this alleged deficiency. Facility's pharmacy will audit all resident medications to ensure none exceed the manufacture's recommended discard date. The corrected action plan will ensure medications dispensed , do not exceed the manufactures recommended discard date. All Nursing staff were re-inserviced regarding the significance of the medication discard date, the necessity of removing them from the medication cart and properly disposing them to ensure no medications are dispensed that exceed the manufacturer's discard date. DON/Designee will audit all resident medications for outdated meds/ biologicals weekly for 60 days then monthly thereafter. The corrected action plan will ensure that all medications exceeding the manufactures recommended discard date are removed and replaced in a timely manner.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	date 3/9/10, discard date 3/9/11; five Oxybutynin CL ER (urinary anti-spasmodic) 5 mg, fill date 3/8/10, discard date 3/8/11; four Spironolactone (water pill) 25 mg, fill date 3/9/10, discard date 3/9/11; 85 Lipitor (cholesterol) 40 mg, fill date 3/16/10, discard date 3/16/11; 92 Tramadol HCl (pain) 50 mg, fill date 4/20/09, discard date 4/20/10; 74 Acetaminophen (pain) 325 mg, fill date 4/20/09, discard date 4/20/10; 17 Diltiazem (blood pressure) 60 mg, fill date 3/16/10, discard date 3/16/11. Center Medication Cart # 2 on 4/14/11 at 2:25 P.M.: Resident # 35: one bottle Timolol gel (eye drops) 0.5%, fill date 12/18/10, open date 1/3/11; one bottle Brimonidine solution (eye drops) 0.2%, fill date 12/2/10, open date 12/3/10. Resident # 39: 71 Fexofendaine HCl (anti-histamine) 180 mg, fill date 11/19/09, use by 11/19/10; 124		The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and recommendations. This will be done monthly for the first ninety (90) days then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Fexofendaine HCl 180 mg, fill date 2/10/10, use by 2/10/11; 29 Potassium Chloride ER (potassium supplement) 20 mEq (milliequivilents), fill date 10/29/09, use by 10/29/10; 89 Lanoxin (heart) 0.125 mg, fill date 2/25/10, use by 2/25/11; 80 Isosorbide Mononitrate ER (heart) 60 mg, fill date 11/28/09, use by 11/28/10. West Medication Room Resident # 10: one bottle Humalog (insulin), fill date 5/20/10, unopened, expiration date 12/2010. Interview on 4/14/11 at 2:45 P.M., LPN # 10 indicated the pharmacy is responsible for checking the medication carts for expired medications. She also indicated that pharmacy last checked the carts on 4/11/11. The Director of Nursing (DON) indicated on 4/14/11 at 4:00 P.M., pharmacy is responsible for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checking the medication carts and the carts are checked monthly by pharmacy. A "(Name) Pharmacy" sheet received on 4/14/11 at 2:00 P.M., from LPN # 1, indicated, "...Xalatan...Discard 6 weeks after date dispensed..." An "Expiration Dates of Medications" sheet, updated 10/2002, received on 4/15/11 at 11:20 A.M., from the DON, indicated, "...Opthalmic (sic) (eye)...solutions...expire 3 months after opening..." (Name) pharmacy, "Medication Room/Cart Inspection Report", received on 4/14/11 at 5:00 P.M., from the DON, indicated the pharmacy checked the carts last on 4/11/11 and 3/10/11. A facility policy titled, "Medication Storage in the Facility", dated, January 2007, indicated, "...Outdated...medications...are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately removed from stock...." 3.1-25(o)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented during the debridement of a MRSA (methicillin-resistant	F0441	**F441** NO RESIDENTS WERE ADVERSLEY AFFECTED BY THIS ALLEGED DEFICIENCY.	05/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Staphylococcus aureaus) infected and draining wound for 1 of 3 residents (#51)observed with open wounds and failed to wash hands after removing soiled linen for 1 of 1 incontinent residents (#32) in a sample of 16. Findings include: 1. During initial tour of the East Unit on 4/11/11 at 10:25 A.M., while accompanied by LPN #1, she indicated Resident #51 was in contact isolation with MRSA (methicillin-resistant Staphylococcus aureus) to an acquired Stage III pressure ulcer on the left heel. Outside the room was a free-standing 3 drawer cabinet which contained gloves and gowns to be worn when providing care to Resident #51. Laboratory reports, dated 3/02/11 and 3/21/11, indicated the wound to the left heel of Resident #51 was positive for MRSA. A "Change of Condition Form," dated 3/09/11, indicated, "...Problem: MRSA to L (left) heel wound. Interventions: ...2. Contact Isolation...." During observation of wound care on 4/13/11 at 11:05 A.M., while accompanied by Physical Therapist (PT)		For resident number 32 and 51 sufficient time has elapsed which precludes the immediate correction of this alleged deficiency. All residents who have their bed linens changed have a potential of being affected by this alleged deficiency. In addition, residents who are in isolation also have a potential of being affected by this alleged deficiency. All nursing and therapy staff were re-inserviced on universal precautions including, but not limited to proper hand washing, contact isolation, proper handling and transporting linens to prevent the spread of infection. This corrected action plan will ensure that the facility practices will actively prevent the spread of infections by following universal precautions. DON/Designee will observe at least 12 nursing/therapy staff for proper hand	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#21, Resident #51 was observed lying in bed. PT #21 addressed the resident and set up her supplies to debride the Stage III pressure ulcer on Resident #51's left heel. PT #21 washed her hands and donned a pair of gloves. She did not wear a protective gown and as she leaned over the bed to position Resident #51 in her bed, PT #21's uniform made numerous contacts with Resident #51's bedding. She removed the old dressing, which contained serous sanguineous drainage, and then debrided dead tissue from the wound. After dressing the wound with a bandage, she discarded her gloves, washed her hands, gathered her supplies, and left the room. PT#21 was queried, as she exited Resident #51's room, about the purpose of the gowns located in the cabinet outside the room. She indicated the aides were supposed to use them when they provided continence care to Resident #51. A facility policy titled, "Contact Precautions (Transmission-based Precautions)," undated, indicated, "...Contact precautions will be used and implemented for residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident...or		washing, handling and transporting linens and contact isolation precaution compliance, weekly at various times and alternate shifts for the next 30 days, then nursing/therapy staff monthly for the next ninety days, then 12 (nursing therapy staff) quarterly thereafter – all, at various times and alternate shifts to ensure staff minimize the transmission of infection. The Administrator/Designee will review these findings weekly and submit his/her observations to the Quality Assurance Committee for further review and re recommendations. This will be done monthly for the first ninety (90) days, then quarterly thereafter or until a 95% compliance threshold is met. By what date the systemic changes will be completed: **May 18, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indirect contact touching environmental surfaces or resident-care items in the resident's room...Gown: 1. "...wear a gown if you anticipate that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room...2. remove gown before leaving the room, ensure that clothing does not come in contact with potentially contaminated environmental surfaces...." 2. Resident #32's diagnoses include, but were not limited to, neurogenic bladder with suprapubic catheter, multiple sclerosis, and muscle weakness. Resident #32's room was observed during a medication pass on 4/12/2011 at 5:10 p.m. and 4/12/2011 at 5:40 p.m.. A strong urine odor was noted during both observations. Resident #32's bed was found to have a wet circular beach ball sized area and a palm sized circular area in the center containing brown matter. An Interview was completed with the Director of Nursing (DoN) on 4/12/2011 at 6:40 p.m.. The DoN stated that wet area was due to perspiration. During an observation on 4/12/2011 at 6:42 p.m., CNA #3 came to the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room and removed soiled sheets from Resident #32's bed without gloves on his hands. CNA #3 placed the soiled sheets in a plastic bag and took the bag to the dirty utility room. CNA #3 went into the dirty utility room and exited immediately with no signs of hand washing or sanitizer use. When asked about hand washing the CNA abruptly stated "You didn't give me a chance." When asked when he would typically wash his hands the CNA stated "I would go into a resident's room." A facility policy titled "Preventing Spread of Diseases," revised 5-15-01, indicated, "...C. Handwashing 1. Staff members are required to wash their hands between residents...D. Linens 1. Staff members handle, store, process, and transport linen so as to prevent the spread of infection. 2. Linens are handles to contain and minimize exposure to any waste products...." 3.1-18(b(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN46552

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE